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### MEMORANDUM

**TO:** Legislative Oversight Committee Members  
Local CFAC Chairs  
NC Council of Community Programs  
County Managers  
State Facility Directors  
LME Board Chairs  
Advocacy Organizations  
MH/DD/SAS Stakeholder Organizations

Commission for MH/DD/SAS  
State CFAC  
NC Assoc. of County Commissioners  
County Board Chairs  
LME Directors  
DHHS Division Directors  
Provider Organizations  
NC Assoc. of County DSS Directors

**FROM:** Dr. Craig L. Gray  
Leza Wainwright 

**SUBJECT:** Implementation Update #68  
Records Management Webpage Established  
Child and Adolescent Day Treatment  
IIH and CST  
SAIOP and SACOT  
ACTT Mid-Size Team Physician Time  
CS Case Management Component  
Endorsement of Day Treatment, Community Support Team and Intensive In-Home

CABHA Physician  
Provider Changes for Targeted Case Management  
Policy Changes for Case Management Services  
Revised PCP Format & One Page Profile  
Important ValueOptions Updates  
Residential Services Levels III and IV Updates

### Records Management Webpage Established

Managing the life cycle of records and complying with records retention and record management requirements are the responsibility of LMEs, providers, and state agency staff. Toward that end, a Records Management webpage has been established on the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) website. The purpose of this webpage is to provide guidance on important areas of records retention and disposition and records management that apply to the administration and provision of publicly-funded MH/DD/SA services. In addition to a PowerPoint presentation on "Record Retention: An Overview of What You Should Know," the webpage includes links to important resources such as workshops and online tutorials developed by the Department of Cultural Resources Government Records Branch as well as guidance on managing electronic records and disaster preparedness and recovery. The state statutes governing public records, the Department of Health and Human Services (DHHS) policy on record retention, the general schedule for state agencies and the DMH/DD/SAS records retention and disposition schedules and forms for the storage and destruction of records can also be accessed from this webpage. The Records Management webpage can be accessed from either the State and Local Government or the Providers of MH/DD/SA Services portals or directly from this link: <http://www.ncdhhs.gov/mhddsas/recordsmgmt/index.htm>.

### **Child and Adolescent Day Treatment**

The Child and Adolescent Day Treatment service definition has been revised, reviewed by the Division of Medical Assistance (DMA) Physician's Advisory Group (PAG), offered for public comment, and received final approval. This definition will be implemented effective April 1, 2010 and can be found in the DMA Clinical Coverage Policy 8A located at: <http://www.dhhs.state.nc.us/dma/mp/8A.pdf>. The day treatment checksheet will be revised to reflect the changes in the service definition and posted to the DMH/DD/SAS endorsement webpage to be utilized to complete the endorsement process for any on site visit effective April 2, 2010. All providers endorsed for this service are expected to be in compliance with the new service definition requirements effective April 1, 2010. All stakeholders, including local management entities (LME), providers, and consumers are encouraged to carefully read this definition as it has been substantially modified.

### **Intensive In-Home and Community Support Team**

The DHHS service definition workgroup has reviewed all public comments for the revised Intensive In-Home and Community Support Team service definitions. In general, comments were supportive of the move to adopt Evidence Based Practices. Concerns were raised regarding training and implementation during this time of significant system transition. Based on these concerns, the specific models listed will be removed from the current drafts. However, a basic foundation in evidence based clinical practices is essential in the delivery of these rehabilitative services. As a result, new draft definitions will include requirements for training in several general clinical best practices. These revised definitions will be re-posted for further comment.

### **Substance Abuse Intensive Outpatient Treatment (SAIOP) and Substance Abuse Comprehensive Outpatient Treatment (SACOT)**

Providers of Substance Abuse Intensive Outpatient Treatment (SAIOP) and Substance Abuse Comprehensive Outpatient Treatment (SACOT) are required to submit a discharge ITR to ValueOptions at the end of a treatment episode or when a consumer leaves the service prior to the end of a treatment episode. This allows ValueOptions to keep an accurate and up-to-date record of treatment days available to the consumer.

Additionally, providers delivering evidence based models (such as the Matrix Model) should submit the specific evidence based practice model name on the ITR when requesting authorization.

### **ACTT Mid-Size Team Physician Time**

This is a correction to the Implementation Update # 65. For a mid-size ACT Team, the required physician time is 24 hour per week, not 32 as previously published.

### **Community Support Case Management Component**

The caseload maximum for the qualified professional has been removed for consumers who are receiving only the case management component of Community Support services. Refer to Implementation Update #65 for further information regarding the case management component of Community Support.

### **Provider Changes for Targeted Case Management**

When a recipient wishes to change to another Targeted Case Management (TCM) provider within the same LME, the TCM providers do not need to send a discharge CTCM or new CTCM to ValueOptions. Currently TCM is authorized to a recipient's LME, thus no provider change request is required when the two TCM agencies are within the same LME.

If the member wishes to change to a TCM provider who is not in the same LME as the previous TCM provider, a provider change prior approval request is required with the following documents:

- CTCM to discharge previous provider
- CTCM to add new provider
- PCP Update

### **Policy Changes for Case Management Services**

Beginning **March 1, 2010**, DMA will change the policies as described below for the following programs: CAP/DA, CAP/Choice, CAP/C, CAP/MR-DD, Targeted Case Management for Persons with Developmental Disabilities, and Early Intervention.

- The maximum number of units for case management services will be limited to no more than three hours (12 units) per calendar month for each recipient. See Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or Medicaid for Children below. Providers should continue to use the current program case management billing codes.
- No more than six additional hours (24 units) may be available if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation.

- It is not necessary to bill all of the additional units on the same claim. These additional units can be used cumulatively within a rolling 365 day period.
- Any billing for assessments and crisis case management above this annual limit will not be paid for adults 21 years of age and older. For children under 21 years of age, requests will be reviewed under EPSDT. (See EPSDT below.)
- These six hours (24 units) are in addition to the three hours per calendar month.
- When billing for these additional six hours/24 units, all programs must use the new procedure code of T1017SC.

Note that these changes apply to Medicaid-funded DD case management. State-funded case management services are authorized in accordance with each LME's benefit plan.

### **Early Intervention (EI)**

Effective March 1 2010, any recipient receiving more than three hours (12 units) of case management per calendar month will have his/her hours reduced to the limit of three hours (12 units). This will not affect the entitlement that is applied under the Early Intervention Program for service coordination as listed in the Individualized Family Service Plan.

Providers may request additional units (additional annual and monthly) by following the EPSDT requirements as outlined on <http://www.ncdhhs.gov/dma/epsdt/>. If the request exceeds the policy limits described above, the request will be reviewed under the EPSDT criteria. If the request meets all of the EPSDT criteria and the requested amount is necessary to meet the child's needs, the request will be approved. If the request does not meet all of the EPSDT criteria or the request exceeds what is necessary to meet the child's needs, the request will not be approved at the level requested.

### **Developmental Disability (DD) Case Management (Waiver and Non Waiver)**

The following procedures apply to providers of DD case management (waiver and non-waiver):

- Current authorizations with effective dates prior to March 1, 2010, will continue as authorized until the next annual continued need review (CNR). The three hour/12 unit limit policy will be applied at the next annual review.
- Effective March 1, 2010, prior authorization of Case Management services for adults on the Supports and Comprehensive Waivers will not be required. These adults will be eligible for up to three hours/12 units monthly as well as the additional 24 units for assessment, planning and crisis management, annually. Non-waiver adults will continue to require prior authorization and may be authorized for up to three hours/12 units per month and no more than six additional hours/24 units if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation. Should a case manager submit a request for non waiver recipient that exceeds the policy limits, the case will be reviewed to determine how many hours/units are necessary to meet the recipient's needs (one, two, or three hours per calendar month and/or six or less additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days).
- Effective March 1, 2010, prior authorization of Case Management services for children on the Supports and Comprehensive Waivers will not be required unless the request exceeds the three hour/12 unit monthly limit or 24 unit limit for assessment, planning and crisis situations. Non-waiver children will continue to require prior authorization.
- Waiver and non-waiver children must be evaluated under the EPSDT requirements prior to reducing their current service level at their next annual review and for authorization requests that exceed the three hour/12 unit limit or the 24 unit limits for assessment, planning and crisis management. See the section below regarding EPSDT.

The case manager may request the additional six hours/24 units (T1017SC) for these current authorizations even if the current monthly authorization is in excess of the three hour/12 units per month. These requests will be reviewed under the EPSDT criteria.

### **All Other Programs (CAP/DA, CAP/Choice, CAP/C)**

- Case management services for all other affected programs will continue as currently approved until the next CNR, or reauthorization is submitted. At that time, the case management unit limits will be applied as specified in the first paragraph of this article.
- All case management units must be documented on the cost summary. It is **important** to note that the conditions set forth in the CAP waiver concerning the recipient's budget and continued participation in the waiver apply. That is, the cost of the recipient's care, including case management services, must not exceed the waiver cost limits specified in the CAP waiver.
- Children will be evaluated under EPSDT requirements prior to taking any adverse action. See the section below regarding EPSDT.

Documentation for case management billable units is required per respective clinical coverage policies. Lack of supportive documentation for billed units will be referred to Program Integrity for possible recoupment.

## **EPSDT**

While the new limit on case management services has been reduced to no more than three hours (12 units) per calendar month and no more than six additional hours (24 units) if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation, these limits may not apply to children under 21 years of age. Federal law, 42 U.S.C. §1396d(r)(5), requires the State Medicaid agency to provide to Medicaid recipients under 21 years of age “necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the [Social Security] Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State [Medicaid] Plan.” For more information about EPSDT and provider documentation requirements for EPSDT requests, please visit

<http://www.ncdhhs.gov/dma/epsdt/>.

## **Recipient Due Process**

### **Children**

As indicated above, all requests for recipients under the age of 21 that exceed policy limits will be reviewed against the EPSDT criteria prior to taking adverse action, and the recipient or his/her legal guardian will receive a written notice explaining the decision. The notice will state the decision and effective date of the reduction, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10), DMA policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), as well as state the EPSDT criteria not met, and an explanation about how to appeal the decision should the recipient or his/her legal guardian so desire.

### **Adults**

If the decision authorizes case management services to the policy limit (three hours per calendar month and/or six additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days), the recipient or his/her legal guardian will receive a written notice explaining the decision. The notice will state the decision and effective date of the reduction to the policy limit, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10) as well as DMA policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), and that pursuant to 42 CFR §431.210 and §431.220(b), the recipient is not entitled to appeal this decision.

Should less than three hours (12 units) per calendar month and/or less than six additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days be authorized, the recipient or his/her legal guardian will receive a written notice explaining the decision, and that he/she is entitled to appeal the decision to authorize less than the policy limit. The notice will state the decision and effective date of the reduction, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10) as well as DMA policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), and an explanation about how to appeal the decision should the recipient or his/her legal guardian so desire.

## **Recipient Notice Regarding Reductions in Case Management Services**

A notice was sent at the end of January to recipients regarding these changes in case management. See the DMA website (<http://www.ncdhhs.gov/dma/pub/consumerlibrary.htm>) for a copy of the notice.

Comments about the reductions in case management services may be sent to the following address:

Division of Medical Assistance  
Clinical Policy Section  
2501 Mail Service Center  
Raleigh, NC 27699-2501

Questions may also be directed to the following areas:

- CAP/DA, CAP/Choice, CAP/C – DMA Community Care Section 919-855-4260
- CAP/MR-DD, DD, EI – DMA Behavioral Health Section 919-855-4290

## **Revised Person Centered Plan Format, Including the One Page Profile**

The person centered plan (PCP) format has been redesigned. The new format has already been put in use by Psychosocial Rehabilitation (PSR) service providers, effective February 1, 2010.

We are pleased to announce that beginning March 1, 2010, for all other services requiring a PCP, the new format **MAY** be used **when the next annual re-write of the PCP is due**. Beginning July 1, 2010, the new format **MUST** be used **when the next annual re-write of the PCP is due**.

- For example, if the date on the current PCP is March 12, 2009, the annual rewrite is due by March 12, 2010 and MAY be completed using the new format. The annual rewrite due the next year, March 12, 2011 MUST be on the new format.
- If the date on the current PCP is August 10, 2009, the annual rewrite is due by August 10, 2010 and MUST be on the new format.
- As of March 1, 2010, there will be **no use of an Introductory PCP** for people new to our system. Service plans for people newly admitted for mental health, developmental disability or substance abuse services on or after March 1, 2010 must be prepared using the new PCP format when a PCP is required. Submission of a prior authorization request with an Introductory PCP on or after March 1, 2010 will be returned by ValueOptions as Unable to Process.
- The PCP must include all services that the person receives, but a PCP is not required if only Basic services are being provided (outpatient treatment and medication management). If an individual is receiving any service which requires a PCP, then the Basic benefit service must be included in the PCP, and no separate plan may be used.

For those who are familiar with the current PCP format, you will find the new design is greatly simplified and shortened. The motivation for the redesign was to lessen the burden on service providers by reducing both paperwork and duplication of effort, while not forfeiting our philosophical commitment to person-centered planning. The new PCP format and supporting documents may be found here: <http://www.ncdhhs.gov/mhddsas/pcp.htm>.

The new PCP format includes:

- One Page Profile
- Action Plan
- Crisis Plan
- Signature Page

**All parts of all sections listed above must be complete or PCPs will be returned as “unable to process” by ValueOptions.**

#### **Updates/Revisions to the PCP**

Updates and revisions to the PCP are made per the current requirements, and must occur when:

- The person’s needs have changed; or
- A provider has changed or been added; or
- Based on assigned target dates for review of the PCP goals; or
- Submission of a PCP revision is required for reauthorization requests.

Additional information on updates/revisions can be found in the Records Management and Documentation Manual (RMDM) found at this link: <http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/rmd09/rmdmanual-final.pdf>.

A new Update/Revision Page and Update/Revision Signature Page are posted along with the new PCP. The changes to both these pages coincide with the revised Action Plan Page and Signature Page found in the new PCP.

- An Update/Revision may be made in the body of the Action Plan of the current PCP, accompanied by the Update/Revision Signature Page.
- If a new goal is added or a significant revision to a goal is made, or any other lengthy narrative update or revision is needed, then use the Update/Revision Action Plan Page to record this, accompanied by the Update/Revision Signature Page.

#### **PCP Instruction Manual**

A revised manual is posted along with the new PCP format and Update/Revision pages. In addition, supplemental pages are posted or will be posted shortly, that include the Person Centered Thinking Tools and Guidelines for use in preparing the One Page Profile and for use by providers to assist in implementation of the PCP.

PLEASE NOTE: This manual will continue to undergo revisions as we work with consultants to provide the best guidance on the preparation and implementation of person-centered plans.

#### **Important ValueOptions Updates**

**Beginning March 1, 2010, notices of new authorization approvals, and the letters will be available only on the ValueOptions online provider portal ProviderConnect.** ValueOptions will end the mailing of paper authorization approval letters as of March 1, 2010. Adverse determination letters will continue to be mailed to the recipient with a copy to the provider. Providers who have not previously used ProviderConnect must register for ProviderConnect at



<https://www.valueoptions.com/pc/eProvider/providerRegisterFromLogin.do>. Training webinars will be conducted in February 2010 to educate providers about the new online approval letter process. Visit [www.valueoptions.com/providers/Network/North\\_Carolina\\_Medicaid.htm](http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm) and scroll to “Provider Training Opportunities” to register for a webinar.

Outpatient requests can now be submitted online via ProviderConnect. Service orders can be uploaded with the online outpatient request in the same manner as one does now for PCPs with online enhanced service requests. Recall, ValueOptions authorizes outpatient services to the provider name and Medicaid number listed in the Billing Provider Name/Number fields. Providers must participate in webinar training before using ProviderConnect to submit service requests for the first time. Go to [www.valueoptions.com/providers/Network/North\\_Carolina\\_Medicaid.htm](http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm) and scroll down to “Provider Training Opportunities” to register for a webinar. Providers who previously completed webinar training for submitting requests need not attend again - the only change to online request submission for outpatient requests is selection of “Outpatient” from the Level of Service drop-down menu.

### **Residential Services Levels III and IV Updates**

#### **Complete Requests for Residential Services**

All required documents must accompany all requests for residential services, regardless of whether requests are deemed as routine or urgent by the submitting provider. Please refer to Implementation Update #60 and #63 for information on all required documents.

Discharge plans must be updated for each concurrent review with updated information related to discharge setting and/or service needs, updated dates and new signatures. However, signoffs on the discharge plan signatures for Level III and Level IV homes may be done by the System of Care (SOC) coordinators every 90 days, unless a significant change in the subject child's well being occurs.

#### **Clarification of Provider Types approved to perform Independent Psychiatric Assessments**

The psychiatric evaluation must be performed by a psychiatrist, psychiatric physician's assistant (PA) who is working under a psychiatrist's protocol, or a Licensed Nurse Practitioner. Effective April 15, 2010, the only Licensed Nurse Practitioners who may perform these assessments will be an Advanced Practice Psychiatric Clinical Nurse Specialist or Advanced Practice Psychiatric Nurse Practitioner.

#### **Endorsement of Day Treatment, Intensive In-Home and Community Support Team Services**

Implementation Update # 63 indicated that endorsement of Day Treatment, Intensive In-Home and Community Support Team services on or after January 1, 2010 would be limited to providers that appeared to meet the criteria to be a Critical Access Behavioral Health Agency (CABHA). As we work to implement CABHA requirements, we are lifting this restriction on endorsement for these three services **at this time**. LMEs should process endorsement requests from potential providers of these three services in accordance with the current DHHS Endorsement Policy. It remains our intent to require CABHA certification for providers to continue to deliver these three services effective July 1, 2010.

#### **CABHA Medical Director**

In response to concerns regarding the availability of psychiatrists, DHHS has established a process for request approval for other categories of physicians to be approved to service as Medical Directors for CABHAs. The Medical Director (half-time or full-time depending upon the caseload size of the agency) of a Critical Access Behavioral Health Agency must be a physician (MD/DO) licensed in North Carolina and enrolled in the Medicaid program with the following credentials:

- Board-certified or board-eligible psychiatrist; or
- Board-certified or board-eligible physician by the American Board of Addiction Medicine (ABAM) licensed in NC or certified by the American Society of Addiction Medicine (ASAM); or
- With specific approval of the Secretary of the Department of Health and Human Services on an individual basis, board-certified or board-eligible in
  - general family practice, or
  - internal medicine, or
  - pediatrics
  - **and with** two or more years of direct service experience diagnosing, treating, and evaluating the effectiveness of treatment of the population to be served by the CABHA, e.g. children or adults with mental illness or substance use disorders.
    - Direct service means face-to-face treatment and interventions as demonstrated by a caseload with patients with a primary mental health or substance use disorder diagnosis and the purpose of the treatment by the physician is related to those diagnoses.
    - Experience attesting to the medical necessity of mental health and substance abuse services does not constitute direct service.

- Consideration will also be given to physicians with these credentials who have received additional training or certification related to treating the populations to be served and those who have prior experience as a medical director for a mental health and/or substance abuse provider organization.

Agencies wishing to request an exception under this policy should email a request explaining why the agency is requesting an exception, a copy of the license of the physician for whom the exception is requested and documentation which verifies the physician's experience with the population to be served to [Contact.DMH.LME@dhhs.nc.gov](mailto:Contact.DMH.LME@dhhs.nc.gov).

Unless noted otherwise, please email any questions related to this Implementation Update to [ContactDMH@dhhs.nc.gov](mailto:ContactDMH@dhhs.nc.gov).

cc:	Secretary Lanier M. Cansler	Sharnese Ransome
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